Rocky Point Acupuncture

Patient Intake Form

PATIENT INFORMATION

Date_____

Name_____

Address_____

City _____ Postal Code _____

Age_____ Birthdate _____

Occupation _____

How did you hear about us _____

CONTACT INFORMATION

Home phone _____

Work phone _____

Other/cell phone _____

Email _____

Care Card Number _____

Primary physician _____

Physician phone number_____

HEALTH HISTORY

What are your primary concerns for coming in for treatment?

1- _____

2- _____

3- _____

How is your sleep? _____

_____

List any Allergies (drugs, foods, etc.)_____

_____

List medications or food supplements you are taking.

_____

_____

List serious illnesses, accidents or surgeries.

_____

_____

Check illnesses that have occurred in blood relatives.

□ Diabetes □ High Blood Pressure □ Stroke

□ Cancer □ Heart Disease □ Kidney Disease

Check symptoms you have or have had in the last year:

- □ Depression
- □ Difficulty in focusing
- □ Dizziness
- □ Easily startled
- □ Excessive worry
- □ Excessive anger
- □ Excessive fear
- □ Fatigue/tiredness
- □ Headaches
- □ Loss of sleep/poor sleep
- □ Loss or gain of weight
- □ Nervousness/irritability
- □ Overwhelmed by life

Check conditions you have or have had in the past:

- □ AIDS
- □ Allergies
- □ Anemia
- □ Arthritis
- □ Bleeding disorders
- □ Breast lump
- □ Cancer
- □ Diabetes
- □ Hepatitis
- □ High/Low Blood pressure

How long has it been since you have had a complete medical exam?

_____

Please see other side

HEALTH HISTORY...CONTINUED

Check symptoms you have or have had in the last year:

MUSCLE/JOINT/BONES

- □ Tremors or Cramps
- □ Swollen joints

Pain, weakness, numbness in:

- □ Arms or Hips
- □ Back Legs
- □ Feet
- □ Neck
- □ Hands
- □ Shoulders
- □ Other_____

EYES/EAR/NOSE/THROAT/RESPIRATORY

- □ Asthma/wheezing
- □ Blurred or failing vision
- □ Difficulty breathing
- □ Earache
- □ Enlarged glands
- □ Eye pain
- □ Frequent colds
- □ Hay fever
- □ Hoarseness
- □ Gum trouble
- □ Nose bleeds
- □ Loss of hearing
- □ Persistent cough
- □ Ringing in ears
- □ Sinus problems

SKIN

- □ Boils
- □ Bruise easily
- □ Dry skin
- □ Itching/rash
- □ Sensitive skin
- □ Sore won't heal
- □ Sweats __ night __ daytime

GENITO/URINARY

- □ Blood/pus in urine
- □ Frequent urination
- □ Inability to control urine
- □ Kidney infection/stones
- □ Lowered libido

GASTROINTESTINAL

- □ Belching, gas or bloating
- □ Colon trouble
- □ Constipation
- □ Diarrhea
- □ Difficulty swallowing
- □ Distention of abdomen
- □ Excessive hunger
- □ Gall bladder trouble
- □ Hemorrhoids (piles)
- □ Indigestion
- □ Nausea
- □ Pain over stomach
- □ Poor appetite
- □ Vomiting

FOR MEN ONLY

- □ Erection difficulties
- □ Penis discharge
- □ Prostate trouble

FOR WOMEN ONLY

- □ Bleeding between periods
- □ Clots in menses
- □ Excessive menstrual flow
- □ Extreme menstrual pain
- □ Irregular cycle
- □ Menopausal symptoms
- □ PMS
- □ Previous miscarriage
- □ Scanty menstrual flow

Could you be pregnant? _____

CARDIOVASCULAR

- □ Chest pain
- □ Hardening of arteries
- □ High or low blood pressure
- □ Pain over heart
- □ Poor circulation
- □ Previous heart attack
- □ Rapid/irregular heart beat
- □ Swelling of ankles

I Verify that the above information is correct to the best of my knowledge and hereby give my full consent for the treatments required. I will not hold this clinic liable for any claims and hereby declare my understanding of the above.
I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____ ***Date*** _____